January 18, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard C1-13-07
Baltimore, MD 21244

Re: *Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care,* CMS-2408-P

Dear Administrator Verma:

Northeast Pharmacy Service Corporation (NPSC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule titled "Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care," which was published in the *Federal Register* on November 14, 2018.[1] NPSC represents more than 250 independent community pharmacies in Connecticut, Massachusetts, Maine, and Rhode Island. Our members are small business owners who are among America's most accessible health care providers.

Independent community pharmacies play a vital role in the Medicaid program; in fact, 17 percent of prescriptions filled by the average independent community pharmacy are covered by Medicaid.[2] More than any other segment of the pharmacy industry, independent pharmacies are often located in the underserved urban and rural areas that are home to many Medicaid recipients, with 75 percent of independent pharmacies serving areas with a population less than 50,000.[3] Local pharmacists provide expert medication counseling and other cost-saving services, such as medication synchronization services, compliance packaging, and home or work site delivery to mitigate the estimated $290 billion spent annually as a result of patient medication nonadherence.

We provide the following comments in an effort to assist CMS in achieving those goals.

I. Network Adequacy Standards

CMS proposes revising network adequacy standards by replacing the requirement for states to establish time and distance standards with a requirement for states to establish a quantitative network adequacy standard. We have concerns with the proposed removal of time and

[1] 83 Fed. Reg. 57264 (Nov. 14, 2018).
[2] National Community Pharmacists Association, 2018 NCPA Digest, 6 (2018).
[3] National Community Pharmacists Association, 2018 NCPA Digest, 12 (2018).

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distance as baseline federal requirements related to network adequacy. NPSC suggests that replacing these standards should be delayed as several oversight provisions related to network adequacy standards did not go into effect until July 1, 2018. It will be useful to appreciate the impact of these standards before implementing significant changes.

Time and distance requirements are common metrics for measuring network adequacy and are used in both the private market and in other government-funded programs, such as Medicare Advantage. These requirements are particularly important for pharmacy network adequacy in the Medicaid program, as limited transportation options can be a concern for many beneficiaries, and NPSC encourages CMS to provide guidance to states on aligning their minimum standards with those already in place in other government-funded programs, such as Medicare Advantage and Medicare Part D. Maintaining a specific quantitative federal requirement for network adequacy standards, such as time and distance, and aligning those standards with other government-funded programs also allows states and CMS to more easily compare network adequacy measures across states and develop appropriate benchmarks.

NPSC also encourages CMS to closely monitor the network adequacy standards each state sets and ensure the states are properly enforcing those standards among the MCOs with which they contract. Appropriate standards and enforcement of those standards are critical to safeguarding beneficiaries' access to care. One area of specific concern related to appropriate pharmacy network adequacy standards and enforcement is beneficiary access to specialty drugs. In some states, MCOs and pharmacy benefit managers (PBMs) inappropriately categorize certain medications as specialty drugs based solely on cost and then force beneficiaries to obtain these medications through a PBM-owned mail order program, when the medications can be readily available at a community pharmacy utilized by the beneficiary. To prevent barriers to access for vulnerable beneficiaries, NPSC encourages CMS to stipulate that states and contracted MCOs and PBMs must follow Medicare Part D regulatory guidance on access to specialty medications.[4]

II. Quality Rating System

CMS proposes to develop a minimum set of mandatory performance measures that will apply equally to federal and alternative quality rating systems (QRS) and to make state and stakeholder consultation in developing these measures more explicit. CMS also proposes to implement cross-program alignment of Medicaid and CHIP QRS with other CMS managed care programs, such as the Medicare Advantage Star Rating System and the QRS for qualified health plans (QHPs), where appropriate. NPSC is committed to ensuring beneficiaries have access to quality pharmacy services and appreciates CMS' intention to align Medicaid QRS mandatory performance measures with other managed care program QRS. As CMS continues to engage

[4] MACPAC December 2018 Public Meeting Tr., 202:11-18, December 2018.

stakeholders and develop performance measures, NPSC encourages CMS to ensure the incorporation of medication use-related metrics, especially in the areas of medication safety, adherence, and appropriate use, taking into account numerous industry-wide concerns regarding the current method of evaluation of pharmacy performance in other managed care programs. The quality-based measures being used to measure pharmacy performance were not developed for use in individual pharmacies.

Applying health plan level measures to individual pharmacies does not provide an accurate reflection of the individual pharmacy's overall quality. There is also a significant lack of standardization among MCOs and PBMs with respect to these measures, causing an inconsistent application of the definition of "quality" to individual pharmacies from various payers. NPSC suggests that CMS define pharmacy quality within the Medicaid QRS and urges CMS to hold MCOs, PBMs, and states accountable for determining standardized, achievable, and proven criteria that appropriately measure individual pharmacy performance, as opposed to criteria that focus on measuring plan performance or criteria which individual pharmacies have little to no opportunity to influence. Efforts are currently underway at PQA to develop quality metrics that can be used at the individual pharmacy level. We think CMS can be advantaged by supporting that effort.

III. Delivery System and Provider Payment Initiatives

Federal statutes require pharmacy reimbursement in the Medicaid fee-for-service program to be "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population."[5] However, these requirements are not necessarily in effect for pharmacy services provided under managed care. Medicaid fee-for-service outpatient drug reimbursement is based on actual acquisition costs and reasonable costs of dispensing for medications and is a more stable and accurate standard for drug reimbursement than other methodologies currently being used. In the absence of protective federal "guardrails," such as those in Medicaid fee-for-service, MCOs and the PBMs subcontracted by them can significantly decrease reimbursement rates, creating a serious financial burden for pharmacy providers and potential access issues for the Medicaid beneficiaries they serve. For these reasons, NPSC strongly recommends CMS provide guidance to states on adopting the Medicaid fee-for-service outpatient drug reimbursement methodology as a minimum fee schedule for pharmacy payments in the Medicaid managed care program.

[5] 42 U.S.C. § 139a(a)(13)(A)(2000).

IV. Accountability and Program Integrity in Subcontractual Relationships

CMS proposes to explicitly require reporting to the Transformed Medicaid Statistical Information System (T-MSIS) of the allowed amount and paid amount for claims when submitting financial data from enrollee encounters. NPSC supports this proposal and the efforts being made by CMS to ensure program integrity. NPSC also strongly encourages CMS to provide guidance to states and MCOs on increasing accountability and program integrity in subcontractual relationships between MCOs and PBMs beyond the proposed changes to reporting of enrollee encounter data.

Recently, states have found that an excessive amount of taxpayer dollars remains with PBMs under managed care. Between 2013 and 2017, the amount that Pennsylvania taxpayers paid to PBMs for Medicaid enrollees more than doubled from $1.41 billion to $2.86 billion.[6] In Ohio, the state auditor found that, of the $2.5 billion that's spent annually through PBMs on Medicaid prescription drugs, PBMs pocketed $224.8 million through the spread alone during a one-year period.[7] Kentucky spends $1.68 billion annually on prescription drugs in the Medicaid managed care program, and evidence suggests PBMs keep as much as $630 million in spread.[8] Louisiana found that PBMs retained $42 million that was incorrectly listed as "medical costs."[9] Based on these findings, states are beginning to take action to increase PBM transparency and accountability in their Medicaid managed care programs and ensure state oversight. Arkansas and Louisiana have implemented a pass-through pricing model for their Medicaid managed care programs, and Ohio made the same decision after a state-commissioned report showed the move could save the state over $16 million while increasing pharmacy reimbursement by over $191 million.[10]

NPSC is committed to pursuing increased accountability and program integrity in Medicaid managed care. Based on the findings and actions of several states detailed above, NPSC suggests that CMS strongly consider model contractual language for subcontractual relationships and delegation between state Medicaid agencies, MCOs, and PBMs, as offered by the National Community Pharmacists Association (NCPA) and to provide guidance to states on increasing accountability and program integrity in subcontractual relationships with PBMs.

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[6] Pennsylvania Auditor General, Bringing Transparency & Accountability to Drug Pricing 6 (Dec. 11, 2018), available at https://www.paauditor.gov/Media/Default/Reports/RPT_PBMs_FINAL.pdf.

[7] Auditor of State of Ohio, Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period, (Aug. 16, 2018), available at https://ohioauditor.gov/news/pressreleases/Details/5042.

[8] Hearing Before the S. Comm. On Health and Welfare, 2018 Regular Session (Ky. Jan. 24, 2018), available at http://www.ncpa.co/pdf/kentucky-testmony-jan2018.pdf.

[9] Melinda Deslatte, Task Force: Is Louisiana Medicaid Drug Spending Inflated?, U.S.NEWS & WORLD REPORT (Oct. 26, 2017), available at https://www.usnews.com/news/beststates/louisiana/articles/2017-10-26/louisiana-spending-on-medicaid-prescription-drugs-questioned.

[10] HealthPlan Data Solutions, LLC, Executive Summary: Report on MCP Pharmacy Benefit Manager Performance, 6 (June 15, 2018).

V. Conclusion

NPSC appreciates the opportunity to share our comments and suggestions with you on the Proposed Rule titled "Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care." If you have any questions, please do not hesitate to contact us.

Sincerely,

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